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Making a Case for Home Health Referral for Older Adults COPD Patients At Risk for 30 Day Readmissions

NORTHSIDE HOSPITAL
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PODIUM PRESENTER:
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Northside Hospital

- 857-bed
- 3 acute care hospitals: Atlanta, Cherokee and Forsyth
- Leads the U.S. in newborn deliveries
- Diagnoses and treats the most cancer cases in Georgia and performs the most surgeries in Georgia
- Ranked #4 on the U.S. News list of the Best Hospitals in GA
- The only Georgia hospital on the Forbes list of America's Best Employers
- More than 2,500 physicians and 11,000 employees
- Serve nearly 2 million patient visits annually across a full range of medical services
- NICHE designated since 2012
- Senior Friendly Status

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Background

- Almost 20% of Medicare patients who are discharged from a hospital are readmitted within 30 days
- Unplanned readmissions accounted for 17% of total hospital payments from Medicare
- Preventing avoidable readmissions has the potential to:
  - Improve quality of life for patients
  - Have a great financial impact in healthcare costs since the readmissions reduction program penalizes hospitals for 30-day readmissions

Jencks SF, Williams MV, Coleman EA. Re-hospitalizations among patients in the Medicare fee-for-service program. N Engl J Med 2009; 360:1418.

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Background

- COPD was included in the CMS measures October 2014
- Although several predictors have been identified as risk factors for COPD readmissions and some interventions proposed, there is not enough evidence of a single strategy to decrease COPD readmission [1]
- Patients discharged home without home health (HH) are at higher risk for readmissions [2]

1. Kripalani, S. et all . Reducing Hospital Readmission: Current Strategies and Future Directions. Annu Rev Med. 2014; 65: 471–485
2. Shah, Tina et all. Understanding Why Patients With COPD Get Readmitted. Chest. 2015 May; 147(5): 1219–1226.

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The problem

- COPD 30 days readmission above national benchmark
- The majority of COPD patients readmitted within 30 days were discharged home on self-care
  - Inadequate post-discharge support and insufficient follow-up are known causes of readmissions

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Objectives

- Investigate root cause for lower rates of home health referral for COPD patients readmitted within 30 days of hospital discharge
- Make recommendations to improve practice

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Methods

Retrospective chart review

- Older adults with COPD discharged home on self-care
- Readmitted within 30 days
- Period: May 2015 to July 2016

Review focused on:

- Need for skilled nursing care after discharge
- Documentation of patient "home bound" status
- Physical Therapy (PT) and Occupational Therapy (OT) consults prior to home discharge
- Function assessment using the Modified Barthel Index (MBI) on admission and discharge

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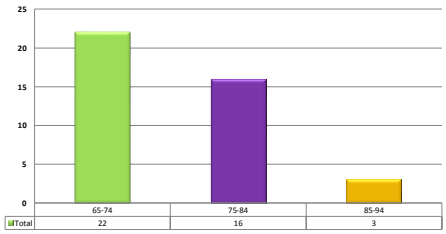
COPD Readmissions by Age Group



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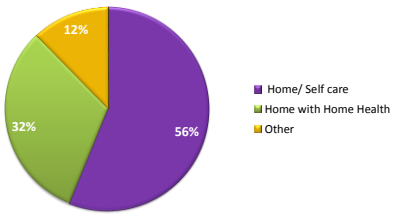
COPD Discharge Disposition May 2015 - July 2016



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Opportunities: Young Old

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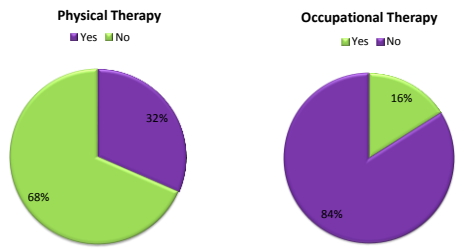
Consults Prior to Discharge



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Findings	%
Functional Decline	26%
Home bound	37%
Skilled care needs	42%

- By Care Coordinators' evaluation
  - 42% of patients discharged home on self care were eligible for home health services

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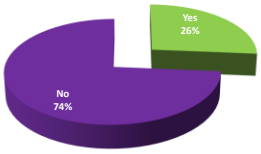
Functional Decline Present at Discharge

- MBI on Admission and Discharge
- 74% either improved or kept baseline function
  - Mobility Protocol
  - Prevention of Functional Decline Education



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Functional Decline	Yes (26%)	No (74%)
Home bound	40%	36%
Skilled Care	80%	29%
Refusal	60%	21%

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Opportunities

- Discharge Disposition
  - Many COPD patients readmitted within 30 days can be appropriate for home health referral either because of home bound situation or need for skilled nursing care
    - Improve screening process
    - Optimize use of MBI
  - Home with Home Health was the second most common discharge disposition for readmitted patients

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Opportunities

- Home Health Refusal
  - Patients presenting with functional decline at discharge, were also most frequently home bound, in need of skilled nursing care but also with higher refusal rate
  - One of the most common reasons:
    - Family/ patient think they "can manage" care after discharge

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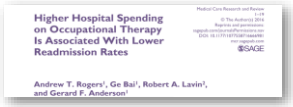
Higher Hospital Spending on Occupational Therapy Is Associated With Lower Readmission Rates

Andrew T. Rogers[1], Ge Bai[1], Robert A. Lavin[1], and Gerard F. Anderson[1]

SAGE

- Occupational therapy (OT) may be in a better position to recognize deficits in self-care and function that might lead to a readmission:
  - Meal preparation
  - Access to medications
  - Bathroom access, toileting
  - Family education
  - Recommendation for alternative discharge plans
- Higher use of OT services has statistically significant association with lower readmission rates for HF, PNA and MI
- By increasing number of OT consults can we help COPD patients and families to recognize function limitations and be more open to post acute care services?

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Interventions/ Work in Progress

- Increase OT utilization
  - Pre-checked item on COPD Order Set

Consults

- ☑ Consult: Occupational Therapy Eval & Tx Decline in Functional Performance / ADL
- ☑ Consult: Speech Therapy Eval & Treat Reason: Decline in Speech Coordination / Swallowing Function
- ☐ Consult: RT Eval & Tx (RT protocol) Reason: _____
- ☐ Consult: Pulmonary Rehab Phase 1 Education
- ☑ Consult: Respiratory Evaluation and Tx Reason: COPD Asthma and peak flow meter education. Proper technique for using devices and self-management. Smoking Cessation if indicated. (NSF & NSC)
- ☑ Consult: Behavioral Health for Smoking Cessation education if indicated (NSA)
- ☑ Consult: Pharmacy to monitor all antibiotics for adjustments due to renal/liver function
- ☑ Consult: Dietician Reason (s): (☑ Nutritional Assessment ☐ Diet Education ☐ Calorie Count)

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Interventions/ Work in Progress

- Care Coordinators and Transition of Care Team Education
  - Patients presenting with functional decline at discharge should be carefully evaluated for post acute care discharge needs
    - Optimize use of MBI
- Explore partnerships with Post Acute Care Programs
  - Barnes Healthy at Home [R]
  - Connecting Partners [R]

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Outcomes

There is not enough evidence of a single strategy to decrease COPD readmission

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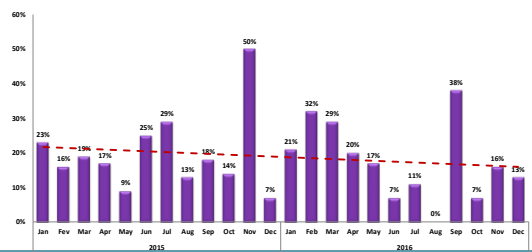
COPD Readmissions Trends



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